

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005809	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2012
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 E COOLSPRING AVE STE 1E MICHIGAN CITY, IN 46360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This was the 2012 ISDH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements at 410 IAC 7-24.</p> <p>Facility Number: 005809</p> <p>Survey Dates: 12/4/2012</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 12, 2012</p> <p>The Facility complied with 410 IAC 7-24, Retail Food Establishment Sanitation Requirements during their routine inspection.</p>	S 000			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

PLZ511

If continuation sheet 1 of 1